Athlete: _____
Date of Injury: _____
Today's Date: _____
Sport: _____

Howard County
RECREATION & PARKS

Medical Clearance for Return to Athletic Participation Following Suspected Concussion or Other Head Injury

To be completed by the Authorized Health Care Provider (AHCP)
(Physician, Nurse Practitioner, Physician's Assistant, Neuropsychologist)

The above-named student-athlete sustained a suspected concussion or other head injury during a practice or game. The purpose of this form is to provide medical clearance before returning to sports participation, as required by Maryland law.

I certify that: I am aware of the current medical standards for evaluation and management of concussions and other head injuries. I have examined the above-named child and he/she is cleared to return to play.

Did the athlete sustain a concussion? Yes ___ No ___

Health Care Provider Name_____

Signature_____ **Date:**_____